Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		NVS5235HOS		B. WING		01/2	1/2010	
NAME OF PR	OVIDER OR SUPPLIER	•	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	•		
SEVEN HILLS BEHAVIORAL INSTITUTE			3021 W HORIZON RIDGE PKWY HENDERSON, NV 89052					
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
S 000 S 105 SS=E	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Initial Comments  Surveyor: 27469 This Statement of Deficiencies was generated a result of a State Licensure re-survey and complaint investigation conducted in your facility on 1/20/10 and finalized on 1/21/10, in accordance with Nevada Administrative Code, Chapter 449, Hospitals.  Complaint #NV00023762 was substantiated with deficiencies cited. (See Tag S0105)  The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.  The following regulatory deficiencies were identified:  NAC 449.322 Housekeeping Services		cility le, with ation d as c, ral, that	S 000				
	Severity: 2 Scope: 2							

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING \_ NVS5235HOS 01/21/2010

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SEVEN HILLS BEHAVIORAL INSTITUTE		3021 W HORIZON RIDGE PKWY HENDERSON, NV 89052					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
S 175	Continued From page 1		S 175				
S 175 SS=F	NAC 449.338 Dietary Services		S 175				
	6. In providing for the preparation and serving food, a hospital shall:  (a) Comply with the standards prescribed in chapter 446 of NRS and the regulations adopursuant thereto  This ELEMENT is not met as evidenced by: Surveyor: 27626  Based on observation, interview and record review on 01/21/10, the facility failed to comwith the provisions of NAC 446.	pted					
	Findings include:  The person operating the dish machine was handling dirty kitchenware and tableware as placed them into the dish machine and then did not wash his hands before handling the cleaned kitchenware and tableware as he removed them from the dishmachine.	he					
	The kitchenware and tableware were not be sanitized as there was no sanitizer being dispensed during the final rinse cycle of the machine.						
	The wash temperature of the dish machine value of the dish machine val	was					
	There were no paper towels at the hand was sink in the food preparation area.	shing					
	The scoop was laying in the flour in the flour and a styrofoam cup was laying in the sugar the sugar bin.						
	There was water pooled under the ice mach	ine,					

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED			
		NVS5235HOS		B. WING	<del></del>	01/2	1/2010		
NAME OF PROVIDER OR SUPPLIER			STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	<u> </u>	00		
SEVEN HILLS BEHAVIORAL INSTITUTE			3021 W HORIZON RIDGE PKWY HENDERSON, NV 89052						
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC) REGULATORY OR L		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	(X5) COMPLETE DATE				
S 175	Continued From page 2			S 175					
	due to the drain line from the ice machine not draining properly to the floor sink.		ot						
	The ceiling vent in the food preparation area had an accumulation of dust and debris.		had						
	Severity 2, Scope 3								
S 340 SS=F	NAC 449.363 Personel Policies			S 340					
	evidence of surveillan employees for tubercuchapter 441A of NAC This Regulation is not Surveyor: 27469 Based on record reviefailed to ensure 6 of 1 compliance with NAC tuberculosis (TB) (Emand #9).  1. The files for Employees #5 and #7 TB skin test.  2. The files for Employees #5.	ees contain documente lice and testing of those ulosis in accordance wi It met as evidenced by: ew on 1/20/10, the facil 1 employees were in	ith ity it, #7 t s for step 7 and						
	examination or certific	cation from a physician a state of good health, culosis and any other	that						
	results of a positive sl a physician that the e	vee #4 did not contain t kin test or a statement mployee had tested po ve a two-step TB test o	from sitive						

Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING \_ NVS5235HOS 01/21/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3021 W HORIZON RIDGE PKWY SEVEN HILLS BEHAVIORAL INSTITUTE HENDERSON, NV 89052 (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) S 340 Continued From page 3 S 340 Severity: 2 Scope: 3